

FORM TO TERMINATE A COLLABORATIVE PRACTICE AGREEMENT

It is important that the Arkansas State Board of Nursing (ASBN) has a copy of your current Collaborative Practice Agreement that identifies your current collaborating physician(s). If you change jobs (or practice sites), have a new collaborating physician, etc., you will need to provide the Board with a new/updated Agreement and Quality Assurance Plan. To terminate your previous Collaborative Practice Agreement, please complete this form (may be submitted via mail, fax, or email). If you have more than one active Collaborative Practice Agreement on file, please submit the one you wish to terminate along with this form. Please contact us if you have any questions. We appreciate your cooperation.

I, _____, am notifying the Arkansas State Board of Nursing that I am
(clearly print first name, last name and title)

terminating my Collaborative Practice Agreement and Quality Assurance Plan with the following physician(s) to be effective on ____/____/____.
mm/dd/year

| | |
|-----------|-----------|
| _____, MD | _____, MD |
| _____, MD | _____, MD |
| _____, MD | _____, MD |
| _____, MD | _____, MD |

I am submitting a **new** Collaborative Practice Agreement, which includes my collaborating physician(s) and Quality Assurance Plan, to be effective on ____/____/____. I understand that I cannot receive or prescribe medications or therapeutic devices until I have submitted the new Collaborative Practice Agreement and Quality Assurance Plan and that I have received verification that these items have been approved.

Signature of APN

Date Signed

Fax: 501.686.2715 (Attention: Ellen Harwell, Licensing Coordinator)

Email: eharwell@arsbn.org

Mail: Arkansas State Board of Nursing
Attn: Ellen Harwell
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Little Rock, AR 72204